

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN0202	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/22/2018
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

GLEN OAKS HEALTH AND REHABILITATION

**1101 GLEN OAKS ROAD
SHELBYVILLE, TN 37160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000, Initial Comments	<p>A Licensure survey and complaint investigation #44710 was completed from 8/20/18 - 8/22/18 at Glen Oaks Health and Rehabilitation. No deficiencies were cited related to the complaint investigation. No deficiencies were cited related to the licensure survey under Chapter 1200-8-6, Standards for Nursing Homes.</p>	N 000		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Cassandra Y. Callahan

Administrator

9/21/18

STATE FORM

6899

6R5Q11

If continuation sheet 1 of 1